This form may be completed online, printed and mailed to the address listed below.

ATTACHMENT D

STATE OF NEBRASKA

Department of Health and Human Services
REGULATION AND LICENSURE - Credentialing Division
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
Telephone #: 402-471-2117

APPLICATION FOR A CHANGE IN OR ADDITIONAL SUPERVISOR
Provisional License in Mental Health Practice or Provisional Certification as a Master Social Work

Must be earning post-master's experience in Nebraska

NO FEE is required

SECTION A – APPLICANT'S PERSONAL INFORMATION (All individuals who will be supervised must complete this section) This information is on the Internet				
1.	Applicant's Name:	First:	Middle:	Last
2.	Public Address:	PO/Street/Route:		
		City:	State:	Zip Code:
3.	OPTIONAL: Telephone #:		PROVISIONAL LICENSE NUMBER:	

SECTION B - SUPERVISOR'S PERSONAL INFORMATION (ONLY IDENTIFY NEW OR ADDITIONAL SUPERVISOR INFORMATION BELOW) – Supervisor(s) must be in Nebraska.						
1.	Supervisor's Name:		First:		Middle:	Last:
	1a	Business Address:	Name of Facility:			
			PO/Street/Route:			
			City:		State:	Zip Code:
	1b	License Number:		Type:	OPTIONAL: Business Telephone #:	
	Supervisor for:		❒ Provisional License in Mental Health Practice		❒ Provisional Certificate in Master Social Work	
2.	Second Supervisor's Name:		First:		Middle:	Last:
	2a.	Business Address:	Name of Facility:			
			PO/Street/Route:			
			City:		State:	Zip Code:
	2b.	License Number:		Type:	OPTIONAL: Business Telephone #:	
	Supervisor for:		❒ Provisional License in Mental Health Practice		❒ Provisional Certificate in Master Social Work	

LICENSES EXPIRE 5 YEARS FROM DATE OF ORIGINAL ISSUANCE

SECTION C - APPLICATION CATEGORY: No FEE is required for a change in supervisor

Your Provisional License/Certificate Number is: _____

❒ Change in Supervisor requested

Name of Previous Supervisor: _____

Should we remove this supervisor as a current supervisor?
❒ yes ❒ no

❒ Additional Supervisor requested
This is in addition to the supervisors already on file

SECTION D - PLAN OF SUPERVISION: Check ***all*** that apply.

These hours must be earned after receipt of an approved master's degree and within the 5 years immediately prior to the date an application for a full license is submitted.

Mental Health Practice Supervision:

Activities: treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, couples, families, or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations.

1. The supervision will start on _____, and should be completed on approximately _____.
2. The supervision will include face-to-face contact for a minimum of one hour per week: ❒ Yes ❒ No If no, state reason why:
_____

Supervisor's Credentials:
❒ qualified physician - **(must submit vitae showing specialized training in mental health or a copy of documentation showing the physician is a board certified psychiatrist)**
❒ licensed psychologist
❒ licensed mental health practitioner

Marriage and Family Therapy Supervision:

Activities: assessment and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems through the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such disorders.

1. I further state the supervised experience: will focus on raw data from clinical work which will be made directly available through such means as written clinical materials, direct observation, and video and audio recording; including a process which is distinguishable from personal psychotherapy or didactic instruction: ❒ Yes ❒ No

2. Additionally, the supervision will include face-to-face contact for a minimum of a cumulative ratio of 2 hours per week per 15 hours of supervisee's contact with clients – no more than 45 hours shall accumulate without supervision, and will not include more than 6 persons at one face-to-face supervisory setting: ❒ Yes ❒ No

Supervisor Credentials:
❒ Training in clinical supervision equivalent to 15 didactic hours, and 3 years of experience supervising the provision of MFT. *(**documentation of training AND supervision must be submitted)***:
❒ "Approved Supervisor" designation certificate from the AAMFT

Master Social Worker Supervision: **Activities (check the activities that will be performed)**

	Yes	No
Information, resource identification and development, and referral services	❒	❒
Preparation and evaluation of psychosocial assessments and development of social work service plans	❒	❒
Case management, coordination, and monitoring of social work service plans in the areas of personal, social, or economic resources, conditions, or problems	❒	❒
Development, implementation, and evaluation of social work programs and policies	❒	❒
Supportive contacts to assist individuals and groups with personal adjustment to crisis, transition, economic change, or a personal or family member's health condition	❒	❒
Social casework for and prevention of psychosocial dysfunction, disability, or impairment	❒	❒
Social work research, consultation, and education	❒	❒
Supervisor's Credentials: ❒ Licensed Mental Health Practitioner and Certified Master Social Worker ❒ Certified Master Social Worker		

Only the new or additional supervisor must complete this section and said experience must be gained in Nebraska to qualify for the Provisional License

SECTION E - SUPERVISOR ATTESTATION (The licensees who will be supervising the applicant's 3,000 hours of post-master's experience must complete this section of the application)

Supervisor Must Complete the following:

I, _____, say that I am the supervisor referred to in this
(Name of Supervisor)

application and that the statements herein are true and complete. I agree to assume legal and professional responsibility for the work of the supervisee listed in this application and agree that I am competent to provide all services identified in this registration form.

_____
(Legal Signature of Supervisor)

_____ date

Second Supervisor Must Complete the following:

I, _____, say that I am the supervisor referred to in this
(Name of Supervisor)

application and that the statements herein are true and complete. I agree to assume legal and professional responsibility for the work of the supervisee listed in this application and agree that I am competent to provide all services identified in this registration form.

_____
(Legal Signature of Supervisor)

_____ date

SECTION F – APPLICANT'S ATTESTATION

Applicant Must Complete the following:

I hereby state that I am the person making application, I am of good moral character, and the statements on this application are true and complete.

_____
(Signature of Applicant)

_____ date

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION & LICENSURE - Credentialing Division
P. O. Box 94986 - LINCOLN, NE 68509-4986
(402) 471-2117

This form must be completed by each supervisor at the conclusion of supervised hours.

AFFIDAVIT OF SUPERVISED EXPERIENCE IN MENTAL HEALTH PRACTICE, MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND/OR SOCIAL WORK

(Print or Type)

STATE OF _____)
) ss
COUNTY OF_____)

***PART I* – All Applicants must complete this part – AFTER COMPLETION OF THE HOURS.**

I, _____ being first duly sworn, state that I am
(supervisor's name)

a qualified supervisor, in the profession of _____ and that I am acquainted

with _____.
(applicant)

***PART II* - Applicants must complete Section A below, if applying for a license as a mental health practitioner; if in addition to the license you are applying for an associated certification, you must also complete either B or C or both. If you are applying only for certification as a master social worker, do not complete section A and B.**

A. Mental Health Practice: (complete this section if you are applying for a mental health practice license)

Activities: treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, couples, families, or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations.

List only the hours that you personally supervised the applicant:

The above named applicant has completed _____ direct (face-to-face) client contact hours and _____ non-direct hours of mental health activities under my supervision within the past 5 years. I further state that I have met with the applicant face-to-face for a minimum of one hour per week: ❒ yes ❒ no. If no, please explain: _____.

Dates of supervision: from _____ to _____.
(month/day/year) **(month/day/year)**

Supervisor's Credentials (please check appropriate credential below):

(for hours earned **before** September 1, 1994):

- ❑ qualified physician ***(must submit evidence the physician is a board certified psychiatrist)***
- ❑ licensed clinical psychologist
- ❑ certified professional counselor
- ❑ certified master social worker
- ❑ qualified for certification as a marriage and family therapist

(for hours earned **after** September 1, 1994):

- ❑ qualified physician ***(must submit evidence the physician is a board certified psychiatrist)***
- ❑ licensed psychologist
- ❑ licensed mental health practitioner

You may make additional copies of this form if supervised by more than one supervisor

B. Marriage and Family Therapy: (complete this section if you are applying for both the mental health practice license and certification as a marriage and family therapist)

Activities: assessment and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems through the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such disorders.

I further state that the supervised experience: focused on raw data from the applicant's clinical work which was made directly available to me through such means as written clinical materials, direct observation, and video and audio recording; included a process which was distinguishable from personal psychotherapy or didactic instruction; and

consisted of _____ direct (face-to-face) client contact hours and _____ non-direct hours under my supervision

from_____ to _____
Additionally, I have met with the applicant face-to-face for a minimum of one hour per week ❑ yes ❑ no
and did not supervise more than six (6) persons at one face-to-face supervisory setting.

Supervisor's Credentials:
❑ 'Approved Supervisor' designation certificate from the AAMFT
❑ Training in clinical supervision equivalent to 15 didactic hours, **AND**
3 years of experience supervising the provision of MFT. ***(documentation of training AND supervision must be submitted)***

C. Master Social Worker: (complete this section if you are applying for both the mental health practice license and certification as a master social worker or if applying only for certification as a master social worker)

Activities: (check below the activities performed)

Yes	No	
❑	❑	1. Information, resource identification and development, and referral services
❑	❑	2. Preparation & evaluation of psychosocial assessments & development of social work service plans
❑	❑	3. Case management, coordination, and monitoring of social work service plans in the areas of personal, social, or economic resources, conditions, or problems
❑	❑	4. Development, implementation, and evaluation of social work programs and policies
❑	❑	5. Supportive contacts to assist individuals and groups with personal adjustment to crisis, transition, economic change, or a personal or family member's health condition
❑	❑	6. Social casework for and prevention of psychosocial dysfunction, disability, or impairment
❑	❑	7. Social work research, consultation, and education

for _____ hours under my supervision from _____ to _____

Supervisor's Credentials:
❑ Licensed Mental Health Practitioner and Certified Master Social Worker
❑ Certified Master Social Worker

PART III – Supervisor's Signature (All supervisors must complete this section)

_____ _____
(Print/type) SUPERVISOR Name and Title Date Signed:

_____
Signature

_____
AGENCY/INSTITUTION

_____
STREET ADDRESS

_____
CITY STATE ZIP